Pacific Coast Foot & Ankle Center, Inc.

PODIATRY, FOOT AND ANKLE SURGEONS
24191 PASEO E VALENCIA, SUITE E
LAGUNA WOODS, CA 92653
OFFICE: 949-855-1177

INSURANCE RELEASE AND PATIENT RESPONSIBILITY FORM

I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS. I AUTHORIZE THE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANY(S). I AUTHORIZE MY PHYSICIAN AND HIS BILLING SERVICE TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY(S). I AUTHORIZE PAYMENT DIRECT TO MY PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL, NOT MY INSURANCE COMPANY(S). I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

NAME OF PATIENT: _____
(PLEASE PRINT FIRST AND LAST NAME CLEARLY)

NAME OF PARENT OR GUARDIAN: _____
(PLEASE PRINT FIRST AND LAST NAME CLEARLY)

SIGNATURE: _____ DATE: _____